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Sen. Gerratana, Rep. Johnson and the Distinguished Members of the Public Health Committee,

In addition to testifying on behalf of Connecticut Right to Life, I am also a 17 year veteran EMT technician and paramedic. Connecticut Right to Life is an organization that promotes the value of human life at all stages from conception until natural death. Our organization is strongly **OPPOSED to HB 6521** and in my professional opinion, believes the POLST program will add confusion and be greatly detrimental to the excellent care currently provided by the EMS system in Connecticut. Our state already has many residents who are confused about terminology dealing with end of life care and the model MOLST program will add to that for providers, families, and clinicians. Many of the terms will be left to greater subjective interpretation

First, the bill's language does not indicate its intent to propose what is called "Physician Orders for Life-Sustaining Treatment". The POLST program establishes a check-box system that is meant to convey a patient's end of life requests that would be communicated to EMS and hospital personnel. These wishes are already conveyed,

The EMS system is established to promote life sustaining treatment for medical and traumatic injuries. The POLST system would **PREVENT** timely treatment intervention simply because of the potential variety of ailments any one person could have. The program revolves around check boxes indicated the following:

1. Resuscitation Status – this would include whether or not to start or continue CPR. When in doubt, emergency personnel begin CPR until it is positively determined a patient has a valid Do Not Resuscitate order signed by their PERSONAL PHYSICIAN. According to POLST guidelines, health practitioners who do not have a personal relationship to the patient could sign such a form. This is unethical and has caused complaints of fraudulent forms at nursing homes across the country where informed consent to POLST was not given by patients.
 - a. The current DNR form in Connecticut is adequate.
 - b. Guidelines on whether a patient would like added interventions such as brief or moderate term respiratory ventilation by the insertion of an intubation device to keep the patient's airway patent or other care is usually given today via Living Wills or other directives and are often abided by today by EMS personnel.
2. "Comfort Measures" – POLST models in other states usually give three options for a patient to receive "comfort measures only", "full treatment" and another check box

that state “limited interventions”. These forms often give five or more variable treatments. For the patient signing the form, again, they may not foresee what therapeutic or negative value any of these treatments may provide in any given circumstance days, weeks, or months before they are confronted it. Such medical decisions are better left to medical personnel at the time they are warranted and a decision whether to proceed with that treatment should be made at that time with the patient’s participation to the extent they can, or their next of kin or conservator.

In my professional life, I have witnessed medical providers and powers of attorney overrule the obvious wishes of a patient, even those who cannot speak but can otherwise communicate their wishes because they prefer to follow the legal guidelines on a living will. I have witnessed one patient in particular who was denied hydration despite the patient’s sister attempting to bring the patient to alternate care givers. In that case, the POA was not able to be reached by telephone and believed to be out of state. Other scenarios have been where a conservator is a social worker and not a member of the family.

3. Antibiotics. The POLST form almost always includes a section asking whether or not patients should receive antibiotics. It is BEYOND MY COMPREHENSION why this is asked to patients before they might suffer from any ailment that could EASILY be alleviated by antibiotics.

Antibiotics are used for the treatment of bacterial infections. Such infections can range from ear and sinus infections, urinary tract infections, all the way up to pneumonia.

When the goal of end of life care is to alleviate the suffering of a patient suffering from kidney failure or cancer or other condition, why not alleviate the most easily curable of ailments –simple infections?

Again, when patients sign these forms, they may not foresee how treating simple everyday ailments could become problematic through this program.

Other treatment for conditions such as hypoglycemia, dehydration and others that are easily treatable can get lost within the language of this program. EMS and healthcare providers are often reminded to treat their PATIENT, and not their technological equipment or pieces of paper with arbitrary checkboxes that were filed before foreseeable illnesses presented themselves. Failing to treat these simple ailments is unethical contrary even to the stated goals of palliative care professionals.

Speaking of ethics, the proposed bill does not include any person on the commission with experience in medical ethics such as clergymen or ethicists. If for some reason this body moves this legislation forward, we implore you to add the input such professionals can provide.

When EMS personnel arrive on the scene of a cardiac arrest – whether it is for a terminally ill patient or an untimely death, we are reminded that we are not only treating the patient, but the family as well. Paramedics have given brief trials of CPR to terminally ill patients at the request of family members. While living wills are not technically incorporated within the EMS protocols in this state, they often serve as a guide for EMS and Emergency Room personnel on how to treat a patient as long as both providers communicate with each other when presented with an out of the box situation.

Instead of introducing this new program, let's improve our current communication tools. Communication between nursing homes or a patient's home is often well documented already. It is the EMT's job to obtain that information and transport it to the hospital with them. Families are usually available on scene or by telephone. HIPPA laws already allow for the portability of communication regarding a patient's wishes to the hospital.

Some current problems we encounter are when a nursing home conveys a "Code A, B, or C" status to emergency personnel. This language isn't commonly known within our field, and it might not even be common between different extended care facilities.

Finally, articles on the POLST website are very concerning. Some of those articles suggest that CPR is an almost useless tool in healthcare. Wording describing medical interventions are also written to distress the reader. For example the description of an intubation of the airway is described as "A tube is put down the throat." The description sounds forceful and painful to the layperson. The actual procedure actually is not painful and often includes the administration of sedation and/or temporarily hypnotic medication so the patient is not aware of procedure and feels no pain or discomfort at all.

We also know that a large number of patients in extended care facilities are not there for long term care at all, but are simply recovering from surgery. In Connecticut, most ECF's provide physical therapy in order to balance their financial stability. CRLC fears that these patients would be forced to sign MOLST forms as well. These forms may create long term confusion as to whether or not they are valid after they leave the facility and have recovered from their temporary illness or injury. Proponents say that it WOULD still be in effect. This is very problematic.

Life is Full of Surprises

A reasonable person would reject MOLST because it is a rigid application to predict the future, regardless of the circumstances when one may encounter a sudden change in their medical

status. Let's say a hospice patient checks a box on the form that rejects any antibiotics. Shortly afterwards, they learn that their daughter is pregnant... or perhaps their grandchild gets engaged and intends to have a quick wedding. These are great human events that drive positive outcomes for our relatives and help them strive to keep fighting their disease.

With one problem – they signed a POLST form.

Let's say that one week before the big wedding or baby delivery, this terminally ill patient acquires a treatable illness as I presented before. They may be awake, but confused and unable to give reliable information. If they have the MOLST form and arrive at the hospital, their illness may not be treated because the caregiver interprets the form as such that she doesn't want to be treated... even though the woman – if she could talk – would want to do everything possible just to make it to the upcoming life event in their family. And then after the event, may be satisfied that they have lived life and then could be at peace with their underlying illness.

This is a scenario that is very plausible in our legalistic culture and society. It already occurs today. We agree with proponents that more education is needed and that conversations about end of life care are shared between family members. Yet, life is a mixed bag of sad but also happy surprises. A check-box fits all form does not fit all the scenarios in life. We urge the committee instead err on the side of life and encourage improving our laws by promoting durable powers of attorney that would be more adept in discerning a patient's wishes through the variety of paths life may lead us down.

Thank you for your consideration of our testimony and feel free to contact me with any further questions or discussion.